

Sharing stories: narrative medicine in an evidence-based world

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Our lives are made up of stories. Stories have a direction and draw the reader into the mystery of what will happen next. Some of our earliest memories are of stories told to us at the end of the day by parents and loved ones. The practice of medicine is lived in stories: “I was well until . . .” “It all started when I was doing . . .” are common openings of the medical encounter.

But stories do more than facilitate conversation. Narrative probes the depths of medical experience [1], and allows for greater understanding of our patients [2], our work, and ourselves [3]. Stories, for the writer, and often for the reader, can be the work of meaning, and even creation [4–7]. This allows for great possibilities. “To do its work, writing creates and recreates the past in the present moment. It reaches into the shadows and pulls what cannot be seen or spoken onto the page where it is open to discussion and revision As writers write to represent, to understand, to integrate experience, they are free to try out alternatives, to see both experience and themselves as they are, as they were, as they might be [8]”. In this way, writing and narrative can be seen as an act of being, paying attention and capturing details of the present moment. Writing narrative is, simultaneously, an act of observing, of becoming, of predicting, and of making choices about how one might act differently or re-write the story, our part or that of others.

Yet stories have an uncertain place in the world of medicine. There is an increasing push toward evidence-based thinking. The anecdote is disparaged as “soft” in contrast with “hard” clinical data. But as details of disease are pursued, there are details of a life that may be left behind [9]. The language of biomedical disease conflicts with the details of patient illness [10,11]. More recently there have been calls for moving beyond “taking” a history from the

patient [12], for the integration of evidence-based medicine and patient-centered care [13,14]. But even patient-centered care is coming to be promoted as a science, and the risk continues of losing the story at the center of the encounter; the patients’, the providers’, the shared narrative that gives context or meaning to the illness for the patient and to the work for the provider [15].

Narrative, or the writing and telling of our story, when we look at it closely, has tangible health and behavioral benefits. The extensive work of Pennebaker and his colleagues demonstrates multiple physical and psychological benefits among varied populations dealing with significant transitions or stress [16–20]. Writing about prior trauma was shown to boost immune response to Hepatitis B vaccination among a sub-group of New Zealand medical students [21]. A recent report demonstrated clinical improvement in lung function (increased PEV1) in patients with asthma, and a reduction in disease activity (measured by disease severity score) in patients with rheumatoid arthritis who wrote about stressful experiences when compared to matched controls who wrote about neutral topics [22]. Writing, demonstrates benefits beyond the medical setting. Maximum security prisoners, crime victims, first time mothers, new college students and engineers who have lost their jobs have all benefited from writing [18–20].

Narrative fits into a broader framework, specifically as one method of reflection. Reflection includes “consideration of the larger context, the meaning, and the implications of an experience or action [23]” and allows the practitioner to integrate and re-work concepts, skills and values into their cognitive framework or understanding. Learning is a cycle of action and reflection [24]. The ability to reflect has emerged as an important physician characteristic for professional development and for learning in the clinical setting [25,26]. Reflective skills are associated with the ability to develop insight into self and learning needs, to direct one’s learning, and ultimately to ensure

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that the physician can practice well autonomously. Reflection allows physicians to become aware of the factors that influence their reactions to and ability to work with patients [27]. Without the opportunity to reflect and become self-aware, attitudes and feelings may go unrecognized, and physician–patient communication may be adversely affected. Unrecognized attitudes and feelings may interfere with the physician's ability to experience and convey empathy [28]; meaningful discussions with patients about difficult topics (bad news, dying and others); engagement with certain patients [29]; and the physician's ability to gather the information necessary to make an accurate diagnosis and to reach agreement with the patient about a treatment plan.

All of these concepts—reflection, narrative writing and collaborative care—are currently written about under the rubric of narrative medicine. The aim of narrative medicine is to develop the skills of fostering empathy, reflection, professionalism, and trust [30]. We need to make more progress toward defining a set of skills associated with narrative competence. For now, interest in hearing the patient's story offers an opportunity to bridge cultures, allay patient fears and concerns, hear patient explanatory models, share uncertainty, and aid in adaptation to chronic illness [9]. These allow for physicians to serve as witness, as healer, or even as co-author of a joint patient–provider encounter [15,31]. *Patient Education and Counseling* seeks to give voice to such narratives to help represent valued viewpoints from the daily work of patients and their providers that may only partially be represented in other reports in the journal.

Instructions for authors/call for papers

Reflective Practice is a new section that will appear periodically in *PEC* to provide a voice for physicians and other healthcare providers, patients and their family members, trainees and medical educators. The title emphasizes the importance of reflection in our learning and how our patient and self-care can be improved through regular practice, similar to other health provider skills. We welcome personal narratives from clinicians of all types on their perspective on caring, patients' perspectives, the patient–provider relationships, humanism in healthcare, professionalism and its challenges, and collaboration in patient care and counseling. Most narratives will describe personal or professional experiences that provide a lesson applicable to caring, humanism, and relationship in health care.

Manuscripts should be 1200 words or less and follow the instructions in the *PEC* Guide for Authors. We welcome unsolicited manuscripts. No abstract is needed. Submit manuscripts through the *Patient Education and Counseling* online, electronic submission system at <http://ees.elsevier.com/pec>. In your cover letter, please indicate that your manuscript is for the *Reflective Practice* section.

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